E-code Workgroup Call
June 19, 2001
Discussion Summary

Participants:

Shereen Brynildsen, NY	Sandra McGuire, OH
Arturo Coto, NE	Donna Pickett, NCHS
Robert Davis, NY	Mary Semon, NY
Marjorie Greenberg, NCHS	Sharon Sprenger, JCAHO
Denise Love, NAHDO	Michelle Williamson, NCHS
Mel Malcolm, OR	Andye Zach, CA

Ms. Zach welcomed the group and reviewed the E-code Workgroup charge: to compile information on current E-coding practice and inventory new developments in state and federal E-code data collection and policies. For example, Mr. Coto informed the group that in Nebraska, E-codes are reportable using the UB92 form by law.

Over the past year, this Workgroup held three conference calls, conducted a cursory literature review and assessment of state data collection practices, and produced a preliminary report and presentation to the Public Health Data Standards Consortium Steering Committee. Acknowledging the pros and cons associated with collecting additional fields, the Workgroup developed consensus recommendations:

- Five E-code fields will be proposed for X12N 837 institutional data reporting. These expanded fields are needed because public health and research purposes require additional E-code fields;
- Adverse effects of medical care E-codes will be included as part of the overall recommendations.

Developing the Business Case

Before promulgating a data standards request, the Workgroup will need to complete and finalize the business case for the additional fields. Justification will include the following factors:

- ICD-10-CM will require a minimum of 3 fields to completely describe the circumstances of injury.

- Many injury registries require 5 fields to describe the injury, accident, drug, and place of occurrence. If administrative data systems are to work in tandem with other public health reporting, this will be an important consideration.

- Most states require some form of E-code reporting. Many states require the UB92 standard (primary E-code only) with their discharge data collection.

California collects 5 fields and Nebraska mandates the reporting of E-codes but it does not specify the number of E-codes to be reported. Ohio requires E-code reporting by tertiary hospitals to a trauma registry and for child death reporting and review purposes. Some providers have difficulty determining what is reportable when specific conditions are targeted, resulting in uneven reporting.

Additional information will be needed to build the business case:

- Percent of records reported to states containing multiple E-codes;

- The (Notice of Proposed Rule Making (NPRM) for Claims Attachments will define a standard claims attachment for Emergency Department clinical data reporting. This is based on Data Elements for Emergency Department Systems (DEEDS). We need to understand components of this proposed standard and how this fits with other data systems, if it does at all.

- Additional information needed: Marjorie referred to the NCVHS report on E-codes, contained in Appendix 6 of the NCVHS 1991 annual report. It is not on the web, but Donna has a hard copy of that report and will scan it and send to the Workgroup. This report will add information about NCVHS E-code recommendations.

- The issue that the provider community uses to oppose E-code reporting is that "it is not needed to pay a claim". The business case will need to include information about medical necessity and how payers use the information to process accident and injury claims.

Adverse Effects

Adverse effects will be included in the final recommendations.

The Workgroup at one time felt that their recommendations should be directed to injury codes only and defer action on adverse effect codes, but the Workgroup now believes that adverse effects should be included in final recommendations. While controversial, these codes are increasingly important to state and federal policy makers. The National Quality Report may include some measures using these codes derived from administrative data. There was general agreement that these E-codes are part of the E-coding structure and the standards are defined. The Workgroup agreed to not focus on adverse/error standards, but include them in the overall recommendations. How these codes are used in data dissemination is another issue and outside of the scope of this workgroup.

Submitting a Work Request

Michelle Williamson and Suzie Burke-Bebee defined the two processes for submitting a work request:

Directly to the Designated Standards Maintenance Organizations (DSMO) Website

- On the 5th business day of the month, all DSMO change requests are batched.
- DSMO have 10 business days to opt in on the specific change requests
- Collaborating Organizations (COs) who opted in will have 90 days to review the change requests and go through a Business Analyses and Recommendations period to perform their analysis and propose a solution
- COs have a 15 day period to attempt to establish a consensus solution. If no opposition, the request is submitted through the X12N standards process.

Directly to X12

- Submitter must complete an ASC X12 Work Request Form including the purpose, scope and business case to the 837 Health Care Claim Work Group (WG)
- The 837 Health Care Claims WG and Data Modeling WG members review the requests, assess the implications of the change requests and vote. The Change Request (CR) must also be submitted to the Technical Assessment S WG, Architecture WG and all other WGs whose guides may be affected by the proposed change request.
- The approved CR must be submitted to the Healthcare Full Task Group for analysis and voting.
- The approved CR must be submitted to the X12 Insurance Full Subcommittee for analysis and voting.

This situational data element would be contained in the Health Information (HI) composite in the 4050 Implementation Guide and we are requesting multiple segments. We will need to assess what support we can expect from the TG2/WG2 (Health Care Claims Workgroup) and try to predict where the opposition will come from, if any. We will request that the 837 Workgroup Co-chairs review the business case and provide advice before the E-code request is formally submitted.

Bob Davis emphasized that multiple E-codes already exist within the 837 Standard in the HI segment, therefore collecting additional E-codes will not require a change to the standard. The issue, from a HIPAA implementation guide perspective, is that only one instance in the HI segment has been allocated for the collection of E-codes in the guide. If additional occurrences are allocated for the collection of E-codes in the implementation guide, it will be possible to collect more E-codes. From inception, the Health Care Services Data Reporting Guide will be designed to accommodate more occurrences of E-codes in the HI segment.

E-coding is an outpatient data collection issue as well, but the inclusion of E-code fields in the 837 professional will be a more lengthy process because no outpatient E-code standard exists at this time. The HI segment is not used in the HCFA 1500, so E-codes would need to go into the diagnosis segment. Attesting diagnosis in outpatient care is a problem and this would impose additional reporting burdens on physicians. Therefore, the 837 institutional will be the target standard. The business case to the content committees (NUBC and NUCC) will be the same, but we will start with the institutional claim and defer the outpatient claim for now.

Bob Davis will include the recommendations in the Health Care Data Reporting Guide for institutional reporting for public health and research purposes and NAHDO will work with Bob to be sure states are aware of the recommendation and its implications for discharge data systems. Bob explained that E-code data collection is problematic. The collection problem may occur at the source of the data as to whether E-codes are being coded accurately and consistently by the Medical Records staff.

Next Steps

1. Donna Pickett will scan the 1991 NCVHS report Appendix into electronic format and circulate to the Workgroup.
2. Denise will request HCUP statistics for multiple E-coding practice by states.
3. The Workgroup will need to draft the business case and circulate the draft to the PHDSC
4. Informally present the business case to the X12N Workgroup chairs, assess the response.
5. Bob will include this recommendation in the Health Care Data Reporting Guide

6. State clearly the support for including E-code fields in the professional and provide this information to Walter Suarez and Denise Koo for NUCC discussions. (Wisconsin Medicaid may have information to justify the outpatient standard and obtaining backing from medical groups that support E-coding will be key).